CITY OF HOLLISTER

REQUEST FOR FAMILY/MEDICAL LEAVE

Employee Name: _____ Date of Request: _____

Department: _____ Position Title: _____

Hire Date: _____

I request a Family/Medical Leave for the following reason (check one):

_____ A. The birth of a child and/or in order to care for such child.

_____ B. The placement of a child for adoption or foster care.

_____ C. In order to care for an immediate family member because such family member has a serious health condition.

Check one: □ CHILD □ SPOUSE □ PARENT
(Must submit "Physician Certification" within 15 days)

_____ D. Employee's own serious health condition that makes the employee unable to perform the functions of his/her position. **(Must submit "Physician Certification" within 15 days)**

METHOD OF LEAVE REQUEST

_____ A. Consecutive Leave

_____ B. Intermittent or Reduced Leave Schedule (Specify schedule below)

_____

_____

Date leave is to begin: _____ Expected duration of leave: _____

If the duration of my family/medical leave (total of paid and unpaid time) does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that if my family/medical leave should exceed 12 weeks, I will be returned to my same or equivalent position, only if available. If my same or equivalent position is not available, I understand that I may be terminated.

_____ _____

Date Employee's Signature